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July 12, 2017

Ms. Seema Verma
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

**Re: CMS–9928–NC** Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients.

*Submitted electronically at www.regulations.gov*

Dear Ms. Verma:

HealthPartners UnityPoint Health (HPUPH), Inc. appreciates the opportunity to provide comments on the Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act and Improving Healthcare Choices to Empower Patients request for information. HPUPH is an Iowa-based health solutions organization formed in 2015 by the largest Iowa health care delivery system, UnityPoint Health and HealthPartners, Inc. a Midwest-based health plan. We are bringing health care and health care financing together so we can deliver on the CMS three-part aim: improving the health of the population served, improving the experience of each individual, and affordability as measured by the total cost of care. HPUPH is new to the market; we began offering coverage to large employer groups and Medicare Advantage in January 2017.

While we are not currently serving the Iowa individual and small employer market, we are committed to a healthy Iowa. Moreover, UnityPoint Health as a health care system serves more than 1 million Iowans and employs more than 26,000 people across Iowa and parts of Illinois and Wisconsin. We know that absence of health insurance often means Iowans will not receive the timely quality health care they deserve.

Our comments provide feedback on possible regulatory changes to improve health insurance options in the small group and individual markets. We want to thank CMS for their work and appreciate this opportunity to comment. HealthPartners UnityPoint Health considers your issue #2, related to market stability, as the most important.

**1. Stabilization of Market Risk Pools (Individuals and Small Groups)**

CMS has requested comment related to "What changes would bring stability to the risk pool, promote continuous coverage, increase the number of younger and healthier consumers purchasing plans, reduce uncertainty and volatility, and encourage uninsured individuals to buy coverage?".

***Individual Market Risk Pools***:

Iowa's market poses unique challenges because its non-ACA compliant market is presently larger than its compliant market. In 2017, over 85,000 Iowans were enrolled in grandfathered or grandmothered plans, which are policies exempt from most of the ACA's insurance reform provisions, and new CMS guidance will allow these plans to continue into 2018. Another 72,000 Iowans are covered through ACA-compliant plans with a majority of them receiving advanced premium tax credits through the federal exchange. It should be noted that these two groups exist in separate risk pools, with most of the media and political attention focused on the viability of the ACA- compliant portion.

Since its inception in 2014, the ACA-compliant market has experienced an overall premium increase ranging from 70 percent to 100 percent. While there were four issuers offering plans in 2017, there is also a strong possibility that Iowa will be the first in the nation to have no health insurance issuer serving the entire state in 2018. This is primarily due to adverse selection in this risk pool resulting from fewer young and healthy enrollees relative to the claims of older and sicker patients. In contrast, the grandfathered /grandmothered market has not experienced this turbulence because its members' health statuses were screened through the pre-ACA underwriting process. It is in response to this crisis that Iowa has recently submitted a 1332 waiver. Without CMS approval of Iowa's 1332 waiver, it is likely that Iowa will have no health insurance issuer serving the entire state in 2018. To help stabilize the risk pool, regulations should encourage greater enrollment.

> **Recommendations**: We commend Iowa's proposal to stabilize the market through its 1332 waiver application and encourage CMS to timely approve this application to bring certainty to the market in the short term. For the long term, the fundamental goal of stabilizing the market must be through the expansion of Iowa's individual market risk pool. This goal can be accomplished through the adoption of the following policies:

- **Encourage Market Competition:** An essential element for stability in both the individual and small group markets is the aggregation and maintenance of risk pools that allow for risk to be spread equitably.

  Currently, the existence of "grandfather/grandmother" plans outside the ACA pools, along with rating rules which distort pricing for certain enrollees, skew the risk within each pool toward older, higher cost enrollees. CMS should encourage new carriers to enter the market through the end of transitional plans. Due to the nature of being grandfathered/grandmothered, a majority of the market is currently frozen in place as legacy carriers have sequestered the healthiest portion of the market. Until and unless those transitional plans' members are released into the active market, it is daunting for potential new competitors to consider a role in the individual market.

- **Introduce Market Support Mechanisms:** The costs of Iowa's sickest residents cannot be sustained by the individual market alone. We urge CMS to provide support through the creation of reinsurance and/or risk corridor mechanisms. To encourage high-value care, subsidies should incentivize efficient health insurance models and care delivery practices. Furthermore, a risk corridor program could be tailored to only new market entrants and phased-out over a three-year period.

  Additionally, the extra costs of high-cost members (in both pools) must be borne by as large a pool as possible to reduce the premium impact to enrollees. We recommend allowing states to develop collective reinsurance programs that cover high cost individual and small group members over an attachment point, and that is financed by carrier assessments based on total commercial revenue. In this way, the entire commercial market bears the costs within the risk pools.

- **Avoid Practices that Narrow the Risk Pool**: To promote confidence in the market, CMS should hold out as paramount the integrity of the risk pool when adopting rules. "Third party premium payments," the desire of third parties (e.g., dialysis centers) to pay the consumer's premium on his/her behalf, is a practice that erodes the risk pool and should not be allowed. By paying the consumer's premium, the third party (a) achieves coverage for the consumer of a type that might not otherwise be in place, and/or (b) achieves dramatically better pricing for their own services, but at the detriment to the larger risk pool.

  In order to stabilize prices and increase enrollment by younger eligible, all individual and small group members must be aggregated into the ACA pools, and pricing for benefit

plans must reflect the historical costs of individual classes of enrollees. This means allowing flexibility around the 3:1 ratio requirement for age based rates and eliminating the "grandfather/grandmother" exemptions.

***Small Group Market Risk Pools***: To protect the viability of the small group market, there should be limited use of self-insurance, which provides an opportunity for adverse selection to occur in the risk pool. Many small businesses are unaware of the new costs associated with self-insurance, coupled with a low attachment point stop loss, and falsely believe this will lead to cost savings. However, not only are these small businesses now responsible for complying with federal regulations, medical and pharmacy claims, but it also contributes to the degradation of the overall market.

While ACA issuers are required by law to guarantee coverage at a community-wide base rate, stop-loss carriers are exempted and can deny their service to a specific small group at the end of their policy contract. When a small business experiences an unanticipated medical cost, for instance an employee has a newborn child with a heart condition; the employer is now liable for financial catastrophe due to the unregulated nature of these policies. The outcome of this example is that the stop-loss carrier will either price out a policy at an extravagant cost or simply not offer renewal to the small business. Ultimately, that small employer will likely return to the fully-insured small group market. This will result in a degradation of the risk pool and in corresponding market-wide premium increases, potentially leading to a death spiral in the market.

**Recommendations**: We recommend that CMS take the following actions to promote the vibrancy of the small group market:

- **Regulate Stop-loss Requirements for Employers**: In alignment with the National Association of Insurance Commissioners' self-insurance subgroup and issue guidance by the DOL and IRS, CMS should clarify that stop-loss policies with low attachment points (when used to enable risk segmentation) are a threat to fully-insured small group markets. The loophole that allows self-funded small groups to avoid some ACA requirements has created unintended risks to employers, providers and members. Small groups who choose to self-fund should demonstrate an ability to pay claims up to the stop-loss attachment point. This will moderate the growth in the small group self-funded market and expand the ACA small group risk pool.

- **Promote Stop-loss Guidance for Carriers:** CMS should provide guidance that states can require stop-loss carriers to use guaranteed issue, community rating and high minimum attachment points for small employers. The stop-loss practice known as "lasering" (i.e.,

removing protections for specific employees or dependents upon stop-loss renewal) should be prohibited.

- **Prohibit Association Health Plans (AHPs)**: As the NAIC stated in their January 24th letter to Congress regarding health care reform, AHPs would "strip states of their ability to protect consumers and create competitive markets". Under their older label of multi-employer welfare associations (MEWAs), association health plans had a long history of fraud, abuse, and exploitation of the gaps between state regulation and federal regulation. Due to their potential for risk segmentation within the market place, we oppose these plans.

**2. <u>Enhancing Affordability</u>**

CMS has requested comment related to "What steps can HHS take to enhance the affordability of coverage for individual consumers and small businesses?". An equally important goal is to reduce the overall cost of insurance for enrollees of ACA plans. As previously referenced, the Iowa ACA-compliant market has experienced an overall premium increase ranging from 70 percent to 100 percent since its inception in 2014.

**Recommendations:** We request that CMS consider the following strategies to enhance consumer affordability:

- **Promote Plan Design and Network Flexibility**: High performing plans should be allowed greater leeway in their plan designs (network adequacy, mandated services) in order to achieve Qualified Health Plan status. Plan efficiency and flexibility will result in greater plan affordability.

- **Price Transparency**: For consumers to make informed decisions about providers and care, transparency of meaningful measures is important. Information on the total cost of care provided should be made readily available in a clear and easy-to-understand manner

  Transparency also requires reporting of non-cost factors including care quality, outcomes of care and patient experience. We support the current efforts to create a STARS-like rating that is visible to enrollees and allows for special enrollment and sales efforts to the highest ranked health plans.

- **Curb Pharmaceutical Costs:** Premium affordability cannot be addressed without examining soaring drug costs. Nationally, the cost of pharmaceutical products has already surpassed hospitalization costs. In 2014, the US health care system spent $373.9

billion on drugs – 13.1% more than it did the previous year and the highest spending growth since 2001. In 2020, this line item is projected to be $435.3 billion. To fully utilize market forces and economies of scale to decrease drug prices, we support efforts to mandate price transparency and explore price controls as part of the FDA approval process, reduce backlog and wait times for generic drugs and biologics, and leverage the power of government programs to reduce costs.

Thank you for the opportunity to provide these comments. We look forward to continuing to be engaged on future regulation development.

Sincerely,

Troy Caraway,
Board Chair